Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

www.dmas.virginia.gov

# MEDICAID MEMO

TO: All Long Stay Hospital, Specialized Care, Alzheimer's Assisted Living Waiver, and Technology Assisted Waiver Respite Care Providers Participating in the Virginia Medical Assistance Programs

FROM: Cynthia B. Jones, Director
Department of Medical Assistance Services

MEMO: Special

DATE: 10/3/2012

SUBJECT: Notification of Long Term Care (LTC) Service Authorization Processing Moving to Keystone Peer Review Organization (KePRO) – ***Effective November 1, 2012***

The purpose of this memorandum is to notify providers rendering specific Long Term Care services that Keystone Peer Review Organization (KePRO) will receive requests for certain services, effective November 1, 2012.

**General Information Regarding Service Authorization**

Service authorization (Srv Auth) is the process to approve specific services for an enrolled Medicaid, FAMIS Plus or FAMIS member by a DMAS enrolled provider prior to service delivery and reimbursement. Some services do not require authorization and some may begin prior to requesting authorization. Providers are instructed to refer to the appropriate provider manual to determine when service authorization is required for specific procedures and to check the DMAS web portal for the most current fee file. The fee file indicates whether a specific HCPCS/CPT requires service authorization for DMAS covered services. Instructions on how to access the fee file are provided within this memorandum.

The purpose of service authorization is to validate that the service requested is medically necessary and meets DMAS criteria for reimbursement. Service authorization does not guarantee payment for the service; payment is contingent upon passing all edits contained within the claims payment process, the member's continued Medicaid/FAMIS eligibility, the provider's continued eligibility, and ongoing medical necessity for the service. Service authorization is specific to an individual member, a provider, a service code, an established quantity of units, and for specific dates of service.

Retrospective review will be performed when a provider is notified of a member's retroactive eligibility for Virginia Medicaid coverage. It is the provider's responsibility to obtain service authorization prior to billing DMAS for these services. Providers must request a service authorization for retrospective review as soon as they are aware of the member's Medicaid eligibility determination.

KePRO's website has information related to the service authorization processes for all DMAS programs they review. Fax forms, web based service authorization checklists, trainings, and much more are on KePRO's website. Providers may access this information by going to http://dmas.kepro.com.

## Long Term Care Services Requiring Service Auth through KePRO

KePRO will begin reviewing requests for the following services, effective November 1, 2012**.** Any requests received through October 31, 2012 at DMAS' Long Term Care Division will be processed at DMAS. KePRO will receive clinical data on these cases and will honor all final determinations made by DMAS. For pend responses issued by DMAS through October 31 2012, providers are to respond to DMAS with the necessary information to complete the final disposition.

Documentation submitted to KePRO will be validated within the clinical record upon post payment review. Inconsistencies may be subject to retraction and/or referral to the Medicaid Fraud Control Unit (MFCU) within the Office of Attorney General.

| **Services** | **PA Service type (used to request service type)** | **Procedure Codes** | **Procedure Code Definition** | **Direct Data Entry (DDE) through Secure Web Portal or Fax Form** |
|---|---|---|---|---|
| Technology Assisted Waiver | 0960 – Technology Assisted Waiver | RESPI (S9125, TE) | Skilled Respite Care, LPN | Direct Entry through KePRO's Atrezzo Connect OR Fax with DMAS 98 *Community Based Care Waiver Request Form* |
| | | RESPI (S9125, TD) | Skilled Respite Care, RN | |
| Alzheimer's Assisted Living Waiver | 0980 - Alzheimer's Assisted Living Waiver | T2031 | Alzheimer's Assisted Living Waiver | Available via Direct Data Entry (DDE) only. **Fax submission not available.** |
| Long Stay Hospital | 1020– Long Stay Hosp/Spec Care | | Long Stay Hospital | |
| Specialized Care | 1020 – Long Stay Hosp/Spec Care | | Specialized Care | |

## Methods of Submission to KePRO

All submission methods and procedures are fully compliant with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state privacy and security laws and regulations. Providers will not be charged for submission, via any media type, for service authorization requests submitted to KePRO.

KePRO accepts service authorization (srv auth) requests through direct data entry (DDE), fax and phone. Submitting through DDE puts the request in the worker queue immediately; faxes are entered by the administrative staff in the order received. To access Atrezzo Connect on KePRO's website, go to http://dmas.kepro.com. For DDE submissions, service authorization checklists may be accessed on KePRO's website to assist the provider in assuring specific information is included with each request. For direct data entry requests, providers must use Atrezzo Connect Provider Portal.

Provider registration is required to use Atrezzo Connect. The registration process for providers happens immediately on-line. From http://dmas.kepro.com, providers not already registered with Atrezzo Connect may click on "*Register*" to be prompted through the registration process. Newly registering providers will need their 10-digit National Provider Identification (NPI) number and their most recent remittance advice date for YTD 1099 amount. The Atrezzo Connect User Guide is available at http://dmas.kepro.com : Click on the *Training* tab, then the *General* tab.

Providers with questions about KePRO's Atrezzo Connect Provider Portal may contact KePRO by email at atrezzoissues@kepro.com. For service authorization questions, providers may contact KePRO at providerissues@kepro.com. KePRO may also be reached by phone at 1-888-827-2884, or via fax at 1-877-OKBYFAX or 1-877-652-9329.

**Specific Information for Submitting Tech Waiver Respite (Service Type 0960)**

Respite under Tech Waiver is not a stand-alone service and is only available to individuals enrolled in the waiver and receiving Private Duty Nursing.

If there has been no claims activity against the current respite service authorization for the past 13 months, then DMAS will end date the service authorization 12/31/2012. DMAS will end date all other respite authorizations, with claims activity in the past 13 months, with an end date in the year 2014 and will provide these to KePRO. The service authorization number for billing respite will not change with the service authorizations that are extended to 2014. Providers will receive a letter generated from the MMIS with the new service authorization end date. Prior to the expiration date of the authorization, if the individual continues to be in need of respite services, the provider must submit a request to KePRO. All respite authorizations will be for a duration of up to 24 months. There is no retroactive authorization, except in the instance of retroactive Medicaid eligibility determination.

Requests may be submitted via KePRO's secure web portal, Atrezzo Connect, or by fax. If submitting by fax, the request must be accompanied by the *DMAS 98 Community Based Care Waiver Request* form. For new cases, providers must submit requests to KePRO within 10 business days of start of care, or the request will be approved starting with the date of receipt. For continued care, providers must submit requests within 14 business days of the current service authorization expiration noted on the MMIS generated letter. KePRO will respond to the request within 5 business days of receiving the request. If the request is pended for additional information, providers must submit all necessary information within the time frame specified by KePRO; do not send information piecemeal when responding to the pend since the information will be reviewed and processed upon initial receipt. If the information is not received within the specified time frame, the request will be sent for higher level review and a physician will make a final determination based on the information received.

When submitting requests for respite, providers must include the reason respite is needed, the dates requested, physician orders and any other pertinent information to justify the need for the service. When submitting requests through Atrezzo Connect, the provider must complete the questionnaire, which contains all pertinent information required to process the request. When submitting by fax, providers are to follow the instructions on the *DMAS 98 Community Based Care Waiver Request* form.

KePRO will utilize criteria as defined in the *Technology Assisted Waiver Manual*, and Virginia Administrative Code.

**Specific Information for Submitting Long Stay Hospital and Specialized Care (Service Type 1020)**

All requests for Long Stay Hospital (LSH) and Specialized Care (SC) must be submitted through KePRO's secure web portal, Atrezzo Connect. Providers are encouraged to register for access to Atrezzo Connect prior to submitting their first request. KePRO will assist providers with the registration process.

KePRO will be entering authorizations on the service authorization file for the providers, based on current information in the MMIS. Providers will receive a letter generated from the MMIS with the new service authorization end date. Prior to the expiration date of the authorization, if the individual continues to be in need of Long Stay Hospital or Specialized Care services, the provider must submit a request to KePRO. Providers

must submit requests within 3 business days of admission, or the authorization will begin on the date the request is received. There will be no retroactive authorizations, except in cases of retroactive Medicaid eligibility determination or Medicare exhaustion. KePRO will review the request within 3 business days of receipt.

Providers must request the service(s) under Service Type 1020, and answer all information contained within the questionnaires in Atrezzo and enter all clinical information to establish medical necessity. In addition to the questionnaire, the provider must upload the Spec 100. Authorizations will be for 1 unit per day, and a duration of up to 365 days. For members who require recertification or are being readmitted back to the facility, the Spec 100 along with clinical information will be required. Readmission can include the individual being discharged from an inpatient hospital stay or returning from therapeutic leave. **Providers must include the service authorization number on their claim in order for the claim to pay.**

KePRO will utilize criteria from the DMAS *Nursing Facility Manual*, and the Virginia Administrative Code.

**Specific Information for Submitting Alzheimer's Assisted Living Waiver (Services Type 0980)**

All requests for Alzheimer's Assisted Living Waiver must be submitted through KePRO's secure web portal, Atrezzo Connect. Providers are encouraged to register for access to Atrezzo Connect prior to submitting their first request. KePRO will assist providers with the registration process. There are several tutorials on KePRO's website specifically for assisting providers with all aspects of service authorization processing.

KePRO will be entering authorizations on the service authorization file for the providers based on current information in the MMIS. Providers will receive a letter generated from the MMIS with the new service authorization end date. Prior to the expiration date of the authorization, if the member continues to be in need of Alzheimer's Assisted Living Waiver services, the provider must submit a request to KePRO.

Providers must submit requests within 10 business days of start of care, or the authorization date will begin on the date the request is received. There will be no retroactive authorizations, except in cases of retroactive Medicaid eligibility determination. If a member has retroactive Medicaid eligibility determination, the provider must submit the request as soon as they receive notification of eligibility determination. KePRO will review the request within 5 business days of receipt.

Providers will request services under Service Type 0980, and the procedure code T2031. KePRO will authorize 1 unit per day, for a duration of up to 365 days. **Providers must include the service authorization number on their claim in order for the claim to pay.** All information needed to process the request is included in the on-line questionnaire within Atrezzo.

KePRO will utilize criteria as defined in the *Alzheimer's Assisted Living Manual*, located on the DMAS website under the *Provider Services, Provider Manuals*. KePRO will also utilize the Virginia Administrative Code.

**Authorizations that Currently Span Past November 1, 2012**

Providers that currently have an approved service from DMAS' Long Term Care (LTC) Division that is approved past November 1, 2012 need to do nothing. The authorization will be honored and there should be no break in the provider's service. Providers must use the service authorization number issued on their approval letter generated from MMIS for submitting claims. If the provider determines that the individual needs a continuance of that approved authorization, the request must be submitted to KePRO prior to the expiration of the initial authorized period. Providers are encouraged to submit the request within 14 days of the expiration date of the current approved time period. KePRO will receive all authorizations that have been performed by DMAS' LTC Division, both denied and approved, that span past November 1, 2012, with the exception of the

Tech Waiver Respite authorization with no claims activity for 13 months, and end dated 12/31/12. If a provider and/or individual appeals any decision made by DMAS' LTC Division, DMAS will act upon the appeal through to resolution.

**General Information for All Submissions**

- There are several tutorials on KePRO's website specifically for assisting providers with all aspects of service authorization processing.

- KePRO will approve, deny, or pend requests. If there is insufficient medical necessity information to make a final determination, KePRO will pend the request back to the provider requesting additional information. Do not send responses to pends piecemeal since the information will be reviewed and processed upon initial receipt. If the information is not received within the time frame requested by KePRO, the request will automatically be sent to a physician for a final determination. In the absence of clinical information, the request will be submitted to KePRO's supervisor for review and final determination. Providers and members are issued appeal rights through the MMIS letter generation process for any adverse determination. Instruction on how to file an appeal is included in the MMIS generated letter.

- There are no automatic renewals of service authorizations. Providers must submit requests for continuation of care needs, with supporting documentation, prior to the expiration of the current authorization.

- Providers must verify member eligibility prior to submitting the request. There are several mechanism available for providers to verify member eligibility, located at the end of this memorandum.

- Authorizations will not be granted for periods of member or provider ineligibility.

- Requests will be rejected if required demographic information is absent.

- Providers must use the forms appropriate for the service(s) being requested.

- Providers should take advantage of KePRO's web based checklists/information sheets for the services(s) being requested. These sheets provide helpful information to enable providers to submit information relevant to the services being requested.

- Providers must submit a service authorization request under the appropriate service type. Service authorization requests cannot be bundled under one service type if the service types are different.

**How to Find Out if Procedure Code(s) Require Service Authorization**

In order to determine if services need to be prior authorized, providers should go to the DMAS website: http://www.dmas.virginia.gov and look to the right of the page and click o the section that says Procedure Fee Schedule Files. You will now see a page entitled DMAS Procedure Fee Files and CPT Codes. Determine whether you wish to use the CSV or the TXT format. The CSV is comma separated value and the TXT is a text format. Depending on the software available on your PC, you may easily use the CSV or the TXT version. The TXT version is recommended for users who wish to download this document into a database application. The CSV version opens easily in an Excel spreadsheet file. Click on either the CSV or the TXT version of the file.

Scroll until you find the code you are looking for. The Procedure Fee File will tell you if a code needs to be prior authorized as it will contain a numeric value for the PA Type, such as one of the following:

00 – No PA is required
01 – Always needs PA
02 – Only needs PA if service limits are exceeded
03 – Always needs PA , with per frequency

To determine whether a service is covered by DMAS, access the Procedure Rate File Layouts page from the DMAS Procedure Fee Files. Flag codes are the section which provides special coverage and/or payment information. A Procedure Flag of "999" indicates that a service is non-covered by DMAS.

## VIRGINIA MEDICAID WEB PORTAL

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, claims status, check status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Xerox State Healthcare Web Portal Support Helpdesk, toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider. Providers may also access service authorization information including status via KePRO's Provider Portal, effective October 31, 2011 at http://dmas.kepro.com.

## ELIGIBILITY VENDORS

DMAS has contracts with the following eligibility verification vendors offering internet real-time, batch and/or integrated platforms. Eligibility details such as eligibility status, third party liability, and service limits for many service types and procedures are available. Contact information for each of the vendors is listed below.

| | | |
|---|---|---|
| Passport Health Communications, Inc.<br>www.passporthealth.com<br>sales@passporthealth.com<br>Telephone:<br>1 (888) 661-5657 | SIEMENS Medical Solutions – Health Services<br>Foundation Enterprise Systems/HDX<br>www.hdx.com<br>Telephone:<br>1 (610) 219-2322 | Emdeon<br>www.emdeon.com<br>Telephone:<br>1 (877) 363-3666 |

## "HELPLINE"

The "HELPLINE" is available to answer questions Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays. The "HELPLINE" numbers are:

| | |
|---|---|
| 1-804-786-6273 | Richmond area and out-of-state long distance |
| 1-800-552-8627 | All other areas (in-state, toll-free long distance) |

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.